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Section

522.001: Massachusetts Insurance Connection for Individuals with AIDS or HIV-Related Diseases

(A) Introduction. The Massachusetts Insurance Connection (MIC) is a health insurance buy-in program administered by the ~~Division of Medical Assistance~~ MassHealth agency for individuals with Acquired Immune Deficiency Syndrome (AIDS) or diseases related to the human immunodeficiency virus (HIV). Individuals who have existing health insurance policies through group or private plans may be eligible to participate in the program, provided their insurance coverage is both comprehensive and cost effective.

(B) Eligibility Requirements. The ~~Division~~ MassHealth agency pays the monthly health insurance premiums of an applicant (and his or her spouse and dependent children if they are already covered under the existing policy) provided that the applicant:

(1) has a health insurance policy (group or private) before becoming eligible for this program (individuals who elect to continue employer-based group health insurance are subject to the provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272) that:

(a) has comprehensive coverage, as determined by the ~~Division~~ MassHealth agency on an individual basis; and

(b) requires premium payments that do not exceed the average monthly cost incurred by the ~~Division~~ MassHealth agency for the care of an individual with AIDS or HIV-related diseases;

(2) has a diagnosis of AIDS or HIV-related diseases;

(3) applies for and meets the Social Security Administration's definition of disability for AIDS or HIV-related diseases;

(4) is a resident of Massachusetts;

(5) in conjunction with his or her spouse and dependent children, has a gross annual income that does not exceed 300 percent of the annualized federal-poverty-level income standard for a household of that size; and

(6) is not eligible for a MassHealth coverage type that provides or pays for comprehensive benefits.

(C) Verifications. Applicants must submit the following verifications to the MIC program coordinator within 45 days of the receipt of the application by the ~~Division~~ MassHealth agency:

(1) a written statement of a diagnosis of AIDS or HIV-related diseases by the examining licensed physician;

(2) documentation of receipt of social security disability benefits or SSI; and

(3) documentation of gross annual income.

(D) Presumptive Eligibility for the MIC Program.

(1) An applicant is presumptively eligible for premium payments through the MIC program on the basis of preliminary information if:

(a) he or she has a diagnosis of AIDS or HIV-related diseases; and

(b) he or she appears to meet the applicable eligibility requirements listed in 130 CMR 522.001(B).

(2) If the SSA determines that the applicant is not eligible for either disability benefits or SSI, the applicant automatically becomes ineligible for program participation and the ~~Division~~ MassHealth agency will discontinue premium payments.

(3) Premium payments made by the ~~Division~~ MassHealth agency on behalf of an applicant who is presumptively eligible are subject to recovery if the applicant is subsequently determined to be ineligible.

(E) Redetermination of Eligibility. The ~~Division~~ MassHealth agency completes a redetermination of eligibility for each program participant on an annual basis, or as needed.

(F) Termination of Benefits.

(1) When any one of the conditions in 130 CMR 522.001(B) no longer apply, the termination of premium payments is effective on the date the next premium payment is due. However, the following exceptions apply:

(a) in the event of the death of a qualified individual who has coverage under a family plan, payment for the continuation of the existing plan will not exceed a period of three months following his or her death; and

(b) if a qualified individual relocates to another state, he or she will be afforded one additional premium payment after relocation to cover the transition period.

(2) The ~~Division~~ MassHealth agency sends written notice to program participants of the termination of premium payments, the reason for the termination, and the individual's right to appeal such termination in accordance with the provisions of 130 CMR 610.000.

522.002: Refugee Resettlement Program

(A) Regulatory Authority. The Refugee Resettlement Program (RRP) is regulated pursuant to Chapter 2 of Title IV of the Immigration and Nationality Act (INA), 8 U.S.C. 1521 et seq.

(B) Overview.

(1) The RRP was established by the Refugee Act of 1980~~.~~ . The Act authorizes funds for the administration and implementation of social and educational services and employment training and placement, as well as cash assistance and medical assistance to refugees without regard to race, religion, nationality, sex, or political opinion~~.~~ . It is the intent of the Act to promote the resettlement and economic self-sufficiency of refugees within the shortest time frame possible.

(2) The Massachusetts Office for Refugees and Immigrants (MORI) is the state agency responsible for the delivery of services to refugees under the Refugee Resettlement Program. The ~~Division of Medical Assistance~~ MassHealth agency has been contracted to provide medical benefits to refugees whom MORI has determined meet the requirements of this section.

(C) Eligibility Requirements. Individuals must submit an application for MassHealth and meet the following requirements:

(1) have valid documentation of refugee status from INS;

(2) be a resident of Massachusetts;

(3) be between the ages of 18 and 64 inclusive;

~~(4) have countable assets of $2,000 or less for an individual, and $3,000 or less for a couple; and~~

(~~5~~4) have ~~income~~ modified adjusted gross income of the MassHealth MAGI household that is less than ~~100~~200 percent of the federal ~~poverty~~ level (FPL) standards or meet a deductible in accordance with 130 CMR 520.028 et seq.; and

(5) be ineligible for MassHealth Standard, CommonHealth, CarePlus, and Family Assistance.

(D) Period of Eligibility.

(1) Eight-Month Eligibility Period. A refugee who meets the requirements of the RRP is eligible to receive MassHealth ~~Standard~~CarePlus for an eight-month period beginning with the date of entry into the United States.

(2) End of Eight-Month Eligibility Period. A refugee who has been in the country for eight months is no longer eligible for MassHealth under the refugee resettlement program~~.~~ . Such refugee will be notified in advance of termination.

(3) Extended MassHealth Eligibility. A refugee who becomes ineligible for MassHealth solely by reason of increased earnings from employment or increased hours of employment will have coverage extended for four months provided the total period of eligibility does not

exceed eight months.

(E) Individuals who were receiving MassHealth Standard benefits through the RRP as of December 31, 2013, will continue to receive MassHealth Standard benefits until the end of the eight-month period from the date on which they began receiving benefits.

522.003: Adoption Assistance and Foster Care Maintenance

Any child placed in subsidized adoption or foster care under Title IV-E of the Social Security Act is automatically eligible for medical assistance provided by the state where the child resides.

(A) Children receiving state-subsidized adoption payments from a state that is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA) will be eligible for medical assistance provided by the state where the child resides if that state is a member of ICAMA.

(B) Children receiving state-subsidized adoption payments from a state that is not a member of ICAMA, or any child receiving state-subsidized foster-care payments will only be eligible for medical assistance provided by his or her state of origin.

522.004: Children's Medical Security Plan (CMSP)

(A) Regulatory Authority. The Children's Medical Security Plan (CMSP) is administered pursuant to M.G.L. c. 118E, §10F.

(B) Overview. CMSP provides coverage to uninsured children under age 19 who do not qualify for any other MassHealth coverage type, other than MassHealth Limited, and who do not have physician and hospital health-care coverage. To apply for these benefits, an applicant must submit an application ~~Medical Benefit Request (MBR)~~ as described in 130 CMR 502.001 and 502.002.

(C) Eligibility Requirements. Children are eligible for CMSP if they are~~:~~

(1) a resident of Massachusetts, as defined in 130 CMR 503.002;

(2) under age 19;

(3) not otherwise eligible for any other MassHealth coverage type, other than MassHealth Limited. ~~Children who are in a waiting period as described at 130 CMR 505.005(H) are considered not eligible for any other MassHealth coverage type. However, c~~Children who are otherwise eligible and who are not receiving MassHealth coverage as a result of not complying with administrative requirements of MassHealth are not eligible for CMSP~~.~~. Children who lose eligibility for MassHealth Family Assistance as a result of nonpayment of premiums or as a result of not enrolling in employer-sponsored health insurance through Premium Assistance are not eligible for CMSP; and

(4) uninsured. An applicant or member is uninsured if he or she:
(a) does not have insurance that provides physician and hospital health-care coverage;
(b) has insurance that is in an exclusion period; or
(c) had insurance that has expired or has been terminated.

(D) Premiums. The premium schedule and payment policies for CMSP are described in 130 CMR 506.011.

(E) Copayments. Members are required to pay copayments for certain covered services. There are no required copayments for preventive and diagnostic services. No member will be exempt from copayment requirements.

(1) The copayments for prescription drugs are~~:~~

(a) $3 for each generic drug prescription; and

(b) $4 for each brand-name drug prescription.

(2) The copayments for dental services are~~:~~

(a) $2 for members with ~~income~~ modified adjusted gross income of the MassHealth MAGI household equal to or below 199.9% of the federal poverty level (FPL);

(b) $4 for members with ~~income~~ modified adjusted gross income of the MassHealth MAGI household between 200.0% to 400.0% FPL; and

(c) $6 for members with ~~income~~ modified adjusted gross income of the MassHealth MAGI household equal to or greater than 400.1% FPL.

(3) The copayments for medical (nonpreventive visits) and mental health services are~~:~~

(a) $2 for members with ~~income~~ modified adjusted gross income of the MassHealth MAGI household equal to or below 199.9% FPL;

(b) $5 for members with ~~income~~ modified adjusted gross income of the MassHealth MAGI household between 200.0% to 400.0% FPL; and

(c) $8 for members with ~~income~~ modified adjusted gross income of the MassHealth MAGI household equal to or greater than 400.1% FPL.

(F) Medical Coverage Date. Except as provided at 130 CMR 522.004(H), coverage begins on the date of the final eligibility determination. The time standards for determining and redetermining eligibility are described at 130 CMR 502.005 and 502.007.

(G) Benefits Provided. Benefits provided are described at M.G.L. c. 118E, §10F~~—~~. Included benefits are:

(1) preventive pediatric care;

(2) sick visits;

(3) office visits, first-aid treatment, and follow-up care;

(4) provision of smoking prevention educational information and materials to the parent, guardian, or the person with whom the enrollee resides, as distributed by the Department of Public Health;

(5) prescription drugs up to $200 per state fiscal year;

(6) urgent care visits, not including emergency care in a hospital outpatient or emergency department;

(7) outpatient surgery and anesthesia that is medically necessary for the treatment of inguinal hernia and ear tubes;

(8) annual and medically necessary eye exams;

(9) medically necessary mental-health outpatient services, including substance-abuse treatment services, not to exceed 20 visits per fiscal year;

(10) durable medical equipment, up to $200 per state fiscal year, with an additional $300 per state fiscal year for equipment and supplies related to asthma, diabetes, and seizure disorders only;

(11) dental health services, up to $750 per state fiscal year, including preventive dental care, provided that no funds will be expended for cosmetic or surgical dentistry;

(12) auditory screening;

(13) laboratory diagnostic services; and

(14) radiologic diagnostic services.

(H) Enrollment Cap. The MassHealth agency may limit the number of children who can be enrolled in CMSP. When the MassHealth agency imposes such a limit, applicants will be placed on a waiting list when their eligibility has been determined~~.~~. When the MassHealth agency is able to open enrollment for CMSP, the MassHealth agency will process the applications in the order they were placed on the waiting list.

(522.005: ~~Healthy Start Program (HSP)~~Reserved)

~~(A) Regulatory Authority. The Healthy Start Program (HSP) is administered pursuant to Chapter 26 of the Acts of 2003 and M.G.L. c. 118E, §10E.~~

~~(B) Overview. To lower the infant mortality rate, HSP provides payment for health care benefits to eligible low-income pregnant women, providing them with early, continuous, and comprehensive prenatal, postpartum, and maternity care. To apply for these benefits, an applicant must submit a Medical Benefit Request (MBR) as described in 130 CMR 502.001 and 502.002.~~

~~(C) Eligibility Requirements.~~

~~(1) Pregnant women and their unborn children are eligible for HSP if their family group gross income is less than or equal to 200% of the federal poverty level and they are:~~

~~(a) a resident of Massachusetts, as defined in 130 CMR 503.002;~~

~~(b) not otherwise eligible for any other MassHealth coverage type, other than MassHealth Limited; and~~

~~(c) not insured for medical care, or have health care insurance that does not cover all medically necessary pregnancy-related care offered by HSP, as described at 130 CMR 522.005(F).~~

~~(2) A family group includes all children under age 19, including unborn children, living in the household and their parents. A parent may be a natural, step, or adoptive parent.~~

~~(D) Period of Eligibility.~~

~~(1) For those determined eligible, coverage begins on the 10th day before the date a completed Medical Benefit Request (MBR) is received at the Central Processing Unit (CPU). If a Request for Information is needed to complete an MBR, all verifications must be received within 60 days of the date of the Request for Information. The time standards for determining and redetermining eligibility are described at 130 CMR 502.005 and 502.007.~~

(2) Once eligibility has been established, benefits for an eligible member will continue throughout the pregnancy, and postpartum care continues for 60 days following the termination of the pregnancy plus an additional period extending to the end of the month in which the 60-day period ends provided eligibility requirements continue to be met. An increase in income above 200% FPL will not cause loss of coverage. A temporary absence from the state will not cause loss of coverage.

(E) Calculation of Financial Eligibility. Financial eligibility for HSP is determined by comparing the family group's gross monthly income with the applicable income standard.

(F) Benefits Provided. Benefits provided are described at M.G.L. c. 118E, § 10E and include all medical care necessary to maintain health during the course of the pregnancy and delivery. Benefits include the following:

(1) primary and specialty visits;

(2) outpatient behavioral health visits;

(3) radiology and laboratory visits;

(4) amniocentesis;

(5) durable medical equipment and supplies, up to $300 per pregnancy;

(6) home nursing visits (two visits for pregnancies without complications and five visits for pregnancies with complications or C-sections);

(7) office visits (including family planning);

(8) inpatient delivery and services (covered by MassHealth Limited);

(9) postpartum obstetric and gynecological care;

(10) newborn hospital and outpatient care, including one postpartum pediatric ambulatory visits;

(11) prescription drugs; and

(12) emergency services (covered by MassHealth Limited).

(G) Provider Regulations. Except as otherwise provided under contract or applicable law, all provisions of 130 CMR 450.000 apply to the Healthy Start Program, including provisions about payment in full (130 CMR 450.203) and medical necessity (130 CMR 450.204).